



Residential/Hospital/Sentinel Event/Assertive Community Treatment (ACT) Incident Report

State Form 53808 (12-08) / DMHA 1011

Instructions: Follow instructions on page 3.
Fax form to 317-233-1986.

Indiana Family and Social Service
Administration
Division of Mental Health and Addiction
402 West Washington Street W353
Indianapolis, IN 46204
Fax: 317-233-1986

Legal Name of Agency:	Name of Residence:
Location/Address of Incident: (number and street, city, state, ZIP code)	
Person Completing Form:	Telephone Number: ()
Type of Report: Check all that apply. More than one type may apply to some incidents. Complete the corresponding matrix below. <input type="checkbox"/> Residential Setting <input type="checkbox"/> Sentinel Event <input type="checkbox"/> ACT <input type="checkbox"/> Hospital/Private Mental Health Institution	

Residential Setting: A report is required within 24 hours of incident.

TRS Transitional Residential

AFA Alternative Family for Adults

SGL Supervised Group Living

SILP Semi Independent Living

Sub Acute Sub Acute Stabilization

Agency Apt. Agency owned bldg/structure

Sentinel Event: A serious and undesirable occurrence involving the loss of life, limb, or function that occurs on the property of the HAP Provider Organization or its subcontractors. A report is required within 24 hours of incident.

Assertive Community Treatment (ACT): A report is required within 24 hours of incident.

Hospital/Private Mental Health Institutions: Incidents involving items 1-5, a verbal report is required within 24 hours and a written report within ten (10) days. Incidents involving items 6-11, a report is required within ten (10) working days.

SETTING AND TYPE OF INCIDENT

Residential Setting: (check only one box) <input type="checkbox"/> 1. TRS <input type="checkbox"/> 2. SILP <input type="checkbox"/> 3. AFA <input type="checkbox"/> 4. Sub Acute <input type="checkbox"/> 5. SGL <input type="checkbox"/> 6. Agency Apt <input type="checkbox"/> 7. Other (specify): <input type="checkbox"/> a. School <input type="checkbox"/> b. Nursing Home <input type="checkbox"/> c. Other (specify):	Residential Incident: 440 IAC 7.5 (check all that apply) <input type="checkbox"/> 1. Fire <input type="checkbox"/> 2. Res temp/perm uninhabitable <input type="checkbox"/> 3. Injury <input type="checkbox"/> 4. Suicide attempt <input type="checkbox"/> 5. Emergency room visit <input type="checkbox"/> 6. Elopement <input type="checkbox"/> 7. Police response <input type="checkbox"/> 8. Alleged exploit., abuse, neglect <input type="checkbox"/> 9. Suicide <input type="checkbox"/> 10. Death <input type="checkbox"/> 11. Other: (specify):	Sentinel Event: (check only one box) <input type="checkbox"/> 1. Loss of Life <input type="checkbox"/> 2. Loss of Limb <input type="checkbox"/> 3. Loss of Function <input type="checkbox"/> 4. Other: (specify) A.C.T.: 440 IAC 5.2 (check all that apply) <input type="checkbox"/> 1. Suicide/Suicide attempt <input type="checkbox"/> 2. Death of consumer <input type="checkbox"/> 3. Documented violation of rights <input type="checkbox"/> 4. Other: (specify):
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Hospital/Private Mental Health Institution: 440 IAC 1.5 (check all that apply) <input type="checkbox"/> 1. Death not related to seclusion or restraints. <input type="checkbox"/> 2. Death while consumer was in restraint or seclusion; within 24 hours after being removed from restraint or seclusion; within one (1) week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to that consumer's death ("reasonable to assume" includes, but is not limited to, deaths related to: (A) restrictions of movement for prolonged periods of time; (B) chest compression; (C) restriction of breathing; or (D) asphyxiation). <input type="checkbox"/> 3. A serious, unexpected consumer injury resulting in or potentially resulting in loss of function and/or marked deterioration in a consumer's condition <input type="checkbox"/> 4. Chemical poisoning resulting in actual or potential harm to the consumer <input type="checkbox"/> 5. Disruption of service exceeding four (4) hours caused by internal disasters, external disasters, strikes by health care workers, or unscheduled revocation of vital services. <input type="checkbox"/> 6. Consumer missing more than 24 hours <input type="checkbox"/> 7. Kidnapping of consumer <input type="checkbox"/> 8. Admission of child (14 & under) to adult unit. <input type="checkbox"/> 9. Documented violation of rights <input type="checkbox"/> 10. Unexplained loss or theft of controlled substance <input type="checkbox"/> 11. Fire/Explosion with emergency response <input type="checkbox"/> 12. Other: (specify)	
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Consumer or Alleged Victim Name:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female	Age:	<input type="checkbox"/> 1. Consumer <input type="checkbox"/> 4. Other (specify): <input type="checkbox"/> 2. AF/ Householder <input type="checkbox"/> 3. Staff/Volunteer
Alleged Perpetrator Name:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female	Age:	<input type="checkbox"/> 1. Consumer <input type="checkbox"/> 4. Other (specify): <input type="checkbox"/> 2. AF/ Householder <input type="checkbox"/> 3. Staff/Volunteer

Date of incident: <i>(mm/dd/yyyy)</i>		
Notification made to: Adult Protective Services (APS) Child Protective Services (CPS) If yes, indicate the date notified: <i>(mm/dd/yyyy)</i> <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a		
Description of Incident:		
Incident Resolution/Agency's Plan of Action:		
Person Submitting Incident Report:		Date: <i>(mm/dd/yyyy)</i>

DMHA Only <i>(Incident Follow Up As Applicable):</i>	
Liaison's Initials:	Date follow up completed: <i>(mm/dd/yyyy)</i>

DMHA only		
Agency Number:	Date DMHA Received Report: <i>(mm/dd/yyyy)</i>	Forward to Liaison: <input type="checkbox"/> yes <input type="checkbox"/> no
Agency Submitted Report Timely: <input type="checkbox"/> yes <input type="checkbox"/> no		

Definitions and Instructions for State Form 53808, Residential/Hospital/Sentinel Event/ACT Incident Report

Identifying Information

Legal Name of Agency: Name under which the agency has been certified.
Name of Residence: Name of the setting where the consumer(s) involved in the incident resides.
Location Address of Incident: Address and/or location where the incident occurred.
Person Completing Form: Name of the person filling out the Residential/Hospital/Sentinel Event/ACT Report form.
Telephone: Telephone number, with area code, where the person who filled out the Residential/Hospital/Sentinel Event/ACT Report form can be reached.
Type of Report: Check any report type that applies. For certain incidents, more than one report type may apply. After you have checked the appropriate report type(s), please go to the corresponding matrix below.

Setting and Type of Incident

Residential Incident Setting	<u>Check only one box in this matrix.</u> The selection should be based on the type of residential setting in which the consumer(s) involved in the incident resides. If the type of residential setting is not represented on the form, please check the <i>Other</i> box and specify the residential setting.
Residential Incident	<u>Check any box in this matrix that applies.</u> If the type of incident that occurred is not represented, please check the <i>Other</i> box and specify the type of incident that occurred.
Sentinel	<u>Check only one box in this matrix.</u> This selection should be based on the type of incident consumer(s) are involved in (i.e. loss of life, limb, or function). If the type of incident that occurred is not represented, please check the <i>Other</i> box and specify the type of incident that occurred.
ACT	<u>Check any box in this matrix that applies.</u> If the type of incident that occurred is not represented, please check the <i>Other</i> box and specify the type of incident that occurred.
Hospital	<u>Check any box in this matrix that applies.</u> If the type of incident that occurred is not represented, please check the <i>Other</i> box and specify the type of incident that occurred.

Resident or Alleged Victim(*Alleged Perpetrator, if applicable*)

Name: Name of the consumer or name of the alleged victim involved in the incident. *If applicable, name of the alleged perpetrator.*
Sex: Check the box that applies to the gender of the person named.
Age: Indicate the Age of the person named.
Category: Check only one box in this matrix. The selection should be based on the category to which the consumer or victim belongs. If the category to which the consumer or victim belongs is not represented, please check the *Other* box and specify the consumer or victim's category.

Date of Incident: Date the incident took place.	
Notification Made To: Check the box in the Adult Protective Services (APS) section that applies. Check the box in the Child Protective Services (CPS) section that applies.	
Date Notified: If either APS or CPS were contacted, write the date that contact occurred. If neither APS nor CPS were contacted, leave this space blank.	
Description of Incident	Write a <u>detailed</u> description of the incident that took place.
Incident Resolution/Agency's Plan of Action	Write a <u>detailed</u> description of how the incident has been resolved and or the agency's plan of action to resolve the incident and if applicable efforts to reduce future occurrences of such incidents.
Person Submitting Report	Name of the person who is submitting the report to DMHA.
Date	Date the form is completed.
DMHA Only	The information in this section is to be completed by DMHA staff only.

Procedure: Complete the Residential/Hospital/Sentinel Event/ACT Incident Report form and fax to DMHA.

DMHA FAX Number: 317-233-1986

Please remember to fax both pages of the completed form.